Health Services
LOS ANGELES COUNTY

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Deputy Director, Strategic Planning

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

October 6, 2014

TO: Supervisor Don Knabe, Chair
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Michael D. Antonovich

FROM: Mitchell H. Katz, M.D.
Director

SUBJECT: **REVISED REIMBURSEMENT RATES FOR PHYSICIAN SERVICES FOR INDIGENTS PROGRAM (PSIP)**

As approved by your Board on October 25, 2011, the Department of Health Services (DHS) is exercising its delegated authority to increase the Fiscal Year (FY) 2014-15 Physician Services for Indigents Program (PSIP) reimbursement rate from 9% to 10.5% of the Official County Fee Schedule (OCFS). This increase is based on an actual surplus for FY 2012-13 and a projected surplus for FY 13-14.

DHS began the public process necessary to implement the proposed PSIP reimbursement rate increase to participating non-County physicians on August 14, 2014, since continuing the reimbursement at the current 9% of OCFS would result in a projected surplus again for FY 2014-15. As required by the October 25, 2011 Board Motion, DHS notified the Hospital Association of Southern California, all participating providers, the Physician Reimbursement Advisory Committee (PRAC), your Board Health Deputies and the County Auditor Controller of the proposed rate increase by sending out a notice of the proposed rate increase and upcoming Public Hearing. The Emergency Medical Services (EMS) Agency conducted the public hearing on September 17, 2014, as part of the EMS Commission meeting business. Attached are the comments received from the providers and other attendees.

PSIP Background

Developed in 1987 to reimburse private physicians for indigent care, PSIP has historically been funded by a combination of: 1) penalty assessments collected for certain criminal offenses and vehicle violations, known as "EMS/Maddy Funds"; 2) Los Angeles County "Measure B" property assessment funds designated for trauma centers (partial offset); and 3) the EMSA. EMSA funds were originally placed into the State budget in 2002 to offset reductions in Proposition 99 Tobacco Tax funds allocated by the California Healthcare for Indigents Program. These EMSA funds were allocated to counties based on each county's share of the financial burden to provide health care services to those who are unable to pay. Unfortunately, the State's Final FY 2009-10 budget eliminated the line item called EMSA, which resulted in a statewide reduction of $24.8 million intended to supplement the physician component of each county's

EMS/Maddy Fund. This resulted in a loss of $8.8 million (or 30 percent of the funding) for Los Angeles County's PSIP Emergency Room (ER) and PSIP Trauma Physician programs.

As a result of this loss of State revenue, the Board approved the PSIP reimbursement rate reduction from 27% to 18% for FY 2009-10 on February 16, 2010. Based on previous projections, the rate remained at 18% for FY 2010-11. However, on October 18, 2011, the Board approved a reimbursement rate reduction to 12% for FY 2010-11 outstanding claims and established the rate at 14% for FY 2011-12 claims. Based on the continuous trends of decreasing revenue and increase in ER claim volume, for FY 2012-13 the rate was decreased to 9%.

DHS actual experience for FY 2012-13, based on the 9% reimbursement rate for ER claims resulted in a surplus of $1,184,233 after all eligible claims were adjudicated. This surplus was subsequently distributed as the law requires remaining funds to be distributed proportionately to all physicians based on claims submitted and paid during that year.

Future of PSIP

With the implementation of the Patient Protection and Affordable Care Act, a significant number of the underinsured or uninsured, low-income residents of Los Angeles County should gradually have health insurance, either through the Medicaid expansion or the State Health Insurance Exchange. This health insurance expansion will have two positive effects on the PSIP program. First, physicians will now be able to bill full Medi-Cal rates for patients for whom they were previously receiving the lower PSIP rate. Second, since a significant portion of the previously under-insured and uninsured will have medical insurance, the number of PSIP claims should drop. Therefore, we anticipate that in subsequent FYs we may be able to further adjust the percentage of the Official County Fee Schedule for reimbursement of PSIP claims. We will monitor the changes in claims and revenues closely and inform your Board if appropriate action is necessary.

If you have any questions, please contact me or Cathy Chidester, EMS Agency Director, at (562) 247-1604.

Attachment

MHK:kf

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

Public Hearing

Physician Services for Indigents Program (PSIP) – Proposed Reimbursement Rate Increase for Services Provided in FY 2014-15

Kay Fruhwirth, EMS Assistant Director, provided a brief history of the PSIP program. Over the past four or five years the funding for indigent patients services has declined. The big decline was in FY 2008-09 when the EMSA Fund was deleted from the Governor's budget so that funding was lost through the State. The program is a combination of funding primarily through the Maddy Fund (SB 612), SB 1773 and some Measure B and Impacted Hospital Program funding. Back in 2012 there was a significant shortfall in funding the PSIP and the reimbursement rate declined to nine-percent of the Official County Fee Schedule (OCFS). At that time the County had to reduce the reimbursement rate to ensure that the available funding would cover the increasing number of physicians enrolled in the program and increasing number of claims being submitted against the decreasing funding. This was done to ensure that adequate funding was available to cover the projected increase in claims. The actual payment of Fiscal Year (FY) 2012-13 claims was not as high as estimated and resulted in a surplus. Based on this experience and the projection that there will be a surplus for FY 2013-14, DHS wanted to reduce the potential of having a surplus for FY 2014-15, and proposed increasing the reimbursement rate for FY 2014-15.

The proposal before you today is to increase the FY 2014-15 reimbursement rate to 10.5% of the OCFS. Johnny Wong from DHS Fiscal Services is attending today's meeting to provide an overview of the PSIP financial performance and the information that went into determining the reimbursement rate increase for FY 2014-15. A summary of the financial performance was distributed.

Johnny Wong, of DHS Fiscal Services, presented the financial overview of PSIP. Current payment of FY 2013-14 PSIP claims are based upon the 9% of the OCFS reimbursement rate. We are using the actual number of claims paid for FY 2012-13 to forecast the payment of claims for FY(s) 2013-14 and 2014-15, and show a small decrease in claims for 2014-15. One of the major factors in causing a decrease in the number of claims is the implementation of the Affordable Care Act (ACA), which took effect on January 1, 2014. Unfortunately, because of claims processing time lags, ranging from four months to seven months from service date, we do not have a clear picture on how the ACA has impacted the number of claims that will be submitted for FY 2014-15. The numbers are only an estimate. We do know that ACA is having some effect on the number of claims paid under PSIP in LA County. To forecast the reimbursement rate for 2014-15, a few months ago, we looked at the national data on the impact of the ACA on uninsured rates and found that uninsured rates declined about 2.5%. We also looked at our uninsured patients, who were currently being billed to the PSIP, to see if we could project what percentage of this population would qualify for Medi-Cal. We found that about 40% of the PSIP patient population did not have a valid social security number and therefore would not qualify for expanded Medi-Cal coverage under ACA.

After the overview of the program and the financial projection, the hearing was opened for public comment and questions.

Commissioner Binch

Q. Who did you coordinate with on your estimation of number of 2014-15 claims?

A. We reviewed and analyzed our in-house claims data provided by AIA (our claims adjudicator), looked at the year-to-date and month-to-month trends, reviewed publications on the impact of the ACA on uninsured rates, and consulted with EMS.

Q. Did you use any independent experts to look at the preliminary numbers?

A. No, other than what was published.

Q. What's the contingency plan if the number of claims is substantially lower than forecasted? Will you be able to reach back and increase or decrease the compensation based on the actual forecast?

A. Each year the funds allocated to the program must be distributed in that year. When there is a surplus at the end of the year, a raise-up is done and the balance is distributed proportionally, as required by law, based on all paid claims processed during that year. DHS is trying to be conservative in its estimate to avoid running out of funds that would warrant any decrease in the reimbursement rate during the year.

General comment made by Commissioner Binch:

I am concerned about the very small amount of the forecast of the proposed rate increase considering we were able to catch up the deficit from previous year and financing this year. With that deficit financed and the Affordable Care Act's impact on the number of claims, I would have hoped to see a higher percentage and if at all possible in any way reconcile that, and compensate all claims based on later revisions.

Commissioner Tillou

Q. When do you anticipate that DHS will start reimbursing at the 2014-15 rate?

A. October 2014, bills will be accepted for the 2014-15 rate.

Q. Do you know what the 2013-14 surplus rate is at this time?

A. No, because we are still paying 2013-14 claims. Currently, we anticipate a $2 million surplus.

Commissioner Flashman

Q. Will the pay-out be expedited? A six to seven month payout is not timely.

A. If we get a clean claim it is paid right away (within 20 working days). If there is a problem with the claim or it is incomplete, it is denied and this process can extend the payment period.

Q. What is the average amount of time it takes for claims to be paid?

A. Kay Fruhwirth indicated that she did not have the exact time but will ask AIA to provide the information on claims processing and will provide this back to the EMSC.

Jamie Garcia, Vice President, Hospital Association of Southern California thanked the EMSC for holding a public hearing on PSIP. He remarked that this was a turning point in a positive direction as we are discussing an increase instead of a decrease in physician reimbursement.

There were no other comments from the audience on PSIP.

PHYSICIAN SERVICES FOR INDIGENT PROGRAM CLAIMS PROCESSING TIME LINE

ER CLAIM

Physician: **90 calendar days** from patient discharge for collection efforts prior to submission of claim

AIA: **20 working days** from receipt of claim to either approve or deny claim

Appeal: Physician has **30 days** to re-submit any denied claim with a maximum of two (2) appeals. If provider is not satisfied with the decision, claim is reviewed by the Physician Reimbursement Advisory Committee (PRAC) for final resolution, which requires adding an additional **20 working days for each cycle** for AIA to process Appeals (paid/denied).

IMPACTED HOSPITAL PROGRAM (IHP)

Same as ER Claim, however; AIA's **20 working days** process time is counted from the date of IHP patient data match (i.e., patient and service date data are matched between hospital claim and physician claim). Since IHP hospitals is given an extended period (between 90 days to 180 days from patient discharge) to submit the claim, the processing time line for IHP claims can range from 150 to 240 calendar days, not including appeals.

OTHER FACTORS

Many other factors are involved that could extend the time from claim submission to payment, which include whether the provider is already enrolled in PSIP or still needs to enroll, claim submission issues, and what specific program (ER, Trauma or IHP) is being billed.